Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN7503	A. BUILDING _____ B. WING _____	08/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD REHABILITATION CENTER	200 MAYFIELD DRIVE SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments During annual licensure survey conducted at Mayfield Rehabilitation Center on August 2 - 4, 2010, no deficiencies were cited in relation to complaints #TN00024574, TN00025420, TN00026134, and TN00026260 under 1200-8-6, Standards for Nursing Homes.	N 000		

Division of Health Care Facilities

Debbie Hankins
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 8/18/10

AUG 19 2010